North Ferriby Nursing Home

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Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This comprehensive inspection took place on 29 October 2015 and was unannounced. We last inspected the service on 30 August 2013 and we found the registered provider was compliant with the regulations.

North Ferriby Nursing Home is located in the village of North Ferriby, in the East Riding of Yorkshire. The service provides accommodation, nursing care and residential care for older people, including those people living with dementia.

The property is a Grade 2 listed building that has been adapted and extended to become a nursing and residential care service. Accommodation is provided over three floors and there is a passenger lift to enable people to access all areas of the service. Communal rooms and bedrooms are spacious and some bedrooms include en-suite facilities. The service has extensive grounds and car parking facilities. The service is in the centre of the village, close to local amenities such as shops, hairdressers, a pharmacy and a public house.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has

Summary of findings

registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found that the recording and administration of medicines was not being managed appropriately in the service. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

During our inspection we found that although people had access to sufficient meals and drinks, people said there was a lack of quality and choice of foods. The dining experience and how people were supported with their nutrition and hydration needs was not always appropriate and information about nutritional and hydration needs was poorly recorded. **This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).**

You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

We identified some concerns about the way the service obtained consent. It was not always clear how the registered provider ensured that individuals had been consulted with about their care needs, and that people had agreed and consented to the care and support being provided for them. The registered manager was in the process of obtaining evidence from families about power of attorney agreements for finances and health and welfare and making sure this was put into people's care files.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

Although relatives told us they had been consulted about people's care, the staff did not record how or when people and families had been involved in the development of people's care and their care plans. We found that people's care plans did not clearly describe their needs. We saw no evidence to suggest that people were not receiving the care they required, but judged that the care provided was not well recorded.

We have made a recommendation on the subject of record keeping and care planning.

There was a quality assurance system in place. However, further work was needed to ensure this was a robust system which assessed, monitored and reviewed the quality of people's experience of the service and took action to ensure improvements to the service were identified and actioned as needed.

We have made a recommendation about quality assurance assessment and monitoring.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were not safe.

The recording and administration of medicines was not being managed appropriately in the service.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults procedures.

Assessments were undertaken of risks to the people who used the service and the staff. Written plans were in place to manage these risks. There was sufficient staff on duty to meet people's needs

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

It was not clearly recorded how individuals had been consulted with about their care needs, and that people had agreed and consented to the care and support being provided for them.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people.

People were given sufficient meals and drinks to meet their needs. However, the dining experience and how people were supported with their nutrition and hydration needs was not always appropriate and information about nutritional and hydration needs was poorly recorded.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience when supporting people. Clear explanations were given to people as tasks were carried out by the staff. This meant people understood what was happening when receiving assistance and support.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

Summary of findings

We found that people's care plans did not clearly describe their needs and did not record how or when people and families had been involved in the development of people's care and their care plans.

People had access to a range of social activities and events within the service that they enjoyed. However, people said they would like to have more trips and activities outside of the service.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Some aspects of the service were not well led.

There was a manager in post who was registered with the Care Quality Commission. People felt the home was well run and they were happy there.

There was a quality assurance system in place. However, further work was needed to ensure this was a robust system which assessed, monitored and reviewed the quality of people's experience of the service and took action to ensure improvements to the service were identified and actioned as needed.

Requires improvement

North Ferriby Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 October 2015 and was unannounced. The inspection team consisted of three adult social care (ASC) inspectors from the Care Quality Commission (CQC) and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the East Riding of Yorkshire (ERYC) Contracts and Monitoring Department and Safeguarding Team. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered provider, registered manager, deputy manager and an administrator. We also spoke with three staff and one visiting health care professional. We spoke in private with four visitors and six people who used the service. We spent time in the office looking at records, which included the care records for three people who used the service, the recruitment, induction, training and supervision records for three members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas of the service and during mealtimes.

Requires improvement

Is the service safe?

Our findings

People and relatives told us that medication on a personal level was handled well. Two people we spoke with said they always got their medicines as prescribed and if they needed anything for pain relief they would just ask a member of staff. We saw the nurse enquiring if people were in pain and administering pain relief medicine as prescribed where needed. People were given drinks to swallow their tablets with and time to take them without rushing.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them and disposed of appropriately. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature.

The nurses and senior care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files. However, we found unsafe practices around the administration and recording of medicines.

Our observations of the qualified staff giving out medicines showed that these were not always administered on time. For example, we saw one nurse still administering the morning medicines (recorded as 08:00) at 10:45. This meant people did not receive their medicines on time and as prescribed. We discussed this with the registered manager who said they were aware that the morning medicine round needed to be more effective.

We saw evidence that staff were signing on the medicine administration record (MAR) to show that medicines had been administered, but when we carried out a spot check of stock we found that these had not always been given appropriately. For example, one person on antibiotics had 23 entries on their medicine administration record (MAR) to say the antibiotics had been administered as one tablet three times a day over eight days. However, checks showed that the pharmacy had only dispensed 21 tablets (a seven day course of antibiotics). This meant staff had signed to record they had administered medicine on occasions when medicine had not been given; and therefore the person using the service did not receive their antibiotics as prescribed, which could mean the course of medicine was not effective.

It is best practice for two staff to sign each handwritten entry on the MAR to show that they had checked that what had been recorded was the same information as was on the medicine label attached to the bottle or box of medicine dispensed by the pharmacy. This was not evident on the hand written entries we saw in the MARs. We found on one entry that the staff had not included the instruction for the medicine to be 'administered with or after food'. This was important as the person receiving the medicine could become nauseous if these instructions were not followed appropriately.

We also saw that staff did not always record the quantities of medicines held for each person. This made it difficult for the staff to audit the medicine stock held in the home. We discussed this with the registered manager who organised with the pharmacy for a new MAR chart to be used in the service. We were later informed that this was in place by 9 November 2015 when the new four weekly cycle of medicines was started. The new chart had a designated line for recording the quantity of medicines received from the pharmacy.

We looked at a selection of topical medicine charts that were kept in people's bedrooms. We found that these were not always completed appropriately. For example, one person's chart instructed staff to apply a cream three times a day. Over a four week period staff had only recorded twice on two separate mornings that the cream had been applied as prescribed. However, discussion with the person prescribed the cream indicated it had been given as directed and the staff had forgotten to sign the chart.

Our checks of the medicine policy and procedure showed that this required updating and developing to include the procedure for ordering medicines, the receipt of medicines, the administration of medicines and the disposal of medicines. We asked the registered manager if they had a copy of the latest good practice guidance on medicine administration and they said, "No, but I will obtain one."

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Requires improvement

Is the service safe?

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. People we spoke with said that they felt safe in the service and visitors told us they had confidence that their relatives were safe living at North Ferriby Nursing Home. One person told us, "I always feel safe with the staff in fact very safe. They all know what they are doing. I can do some things for myself and they support me to keep going." Another person who was wheelchair dependent said staff were always careful when using the hoist. This person told us, "The staff are very competent, they make me feel safe even when transferring me."

However, we did observe two staff members moving one person into a chair from a wheelchair and we noted that they did not give the person any time to try and help themselves and take their own weight. They (staff) both stood in front of the person and hooked their arms into the person's armpits and lifted them into a chair. We reported this poor practice to the registered manager who said that this was not usual practice and went immediately to the staff to speak with them. Checks of the staff training files showed that staff were up to date with moving and handling training.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse (SOVA). The registered manager described the local authority safeguarding procedures. This consisted of a risk matrix tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. There had been instances when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the registered manager took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with three staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident their registered manager would take any allegations seriously and would investigate. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that all staff were up-to-date with safeguarding training.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond to and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives. However, we had concerns about people's safety and the use of stairs leading down into the basement level of the service. Following our inspection the registered manager sent us copies of risk assessments they had completed for the stairs. The registered manager told us they had consulted current guidance on the Health and Safety Executive website (HSE) and used their guidelines to complete the risk assessments showing how the risks were minimised by locking the entrance to the stairs when not in use by staff.

We looked at a selection of accident/incident forms completed by the staff over the last year. The registered manager told us that once they had looked at the forms they were filed in each person's care folder as appropriate. There was no evidence to indicate the registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and acted upon as needed. The registered manager confirmed to us that they did not carry out an audit of accidents/incidents, but said they would start to do so with immediate effect.

Discussion with the registered manager and checks of the records held in the service showed that a dependency level tool was used by the registered manager to calculate the staffing levels required to meet the needs of people who used the service. We were given a copy of the tool used to calculate staffing levels in January 2015 and the registered manager said it would be reviewed as people's needs changed or numbers in the home went up or down.

When we asked people who used the service and relatives if there were enough staff on duty we received a mixed response. Some felt there were enough on duty but others said there were times they were short staffed. We noted there were times during the inspection when there were no

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Is the service safe?

staff in the conservatory area and some of the more able people who used the service were noted to be encouraging other less able people to stay in their chairs. One person explained "I keep an eye on [Name] and call to them to sit still [Name] is pretty good and usually sits back down." Another person told us, "I quite often have to wait for staff, they get very busy. It is better at night strangely." One relative said, "I feel there is enough staff and they all seem to know [Name]."

Discussion with the staff indicated that they felt they were extremely busy at times but that they worked together well as a team to make sure people received the care and support they needed.

We looked at the rota sheets for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rota sheet. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of nurses, care staff, ancillary workers, administrator, activity coordinator, catering staff and maintenance personnel.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm and the nurse call bell, moving and handling equipment including hoists, portable electrical items, electrical systems, water systems and gas systems.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

The registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. This was last reviewed in September 2015.

Personal emergency evacuation plans (PEEP's) were not completed individually for people who would require assistance leaving the premises in the event of an emergency. At the time of the inspection we saw that there were lists on the wall of each unit which gave staff basic information about each person's ability to evacuate the building in an emergency. Discussion with the registered manager at the end of the inspection indicated that they would take action to produce individual PEEP's in future.

We looked at the recruitment files of three members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice. We were also shown evidence that the service carried out checks on overseas staff to ensure they had a 'Right to Work' in the United Kingdom.

We found the level of cleanliness in the service was satisfactory. However, there were some areas of the service that needed attention including the laundry area. These were of low risk to the people using the service and had a low impact on their daily lives. We gave feedback to the registered manager that they needed to audit the levels of infection prevention and control within the service to make sure their practices were effective. The laundry floor and walls required sealing/painting to make them impermeable when staff were cleaning them. The sinks in the laundry room were dirty and needed a deep clean. We received information from the registered manager following our inspection that indicated this work had been carried out.

Requires improvement

Is the service effective?

Our findings

People and their relatives reported that the home provided effective care overall. People said they felt the staff were supportive, well trained and gave them good support. One relative told us, "The staff know [Name] well what they like and how to look after them."

The staff monitored people's health and wellbeing. People were able to talk to health care professionals about their care and treatment. We saw evidence that individuals had input from their GP's, district nurses, chiropodist, opticians and dentists. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). One relative told us, "We are very happy with the overall care. The staff are really honest, very supportive and will go the extra mile. For example, [Name] needed to attend hospital and the staff member went with them in their own time. Everyone keeps us fully informed; they take time out to communicate with us."

Feedback from health care professionals on the effectiveness of the care was positive. For example, one health care professional who gave us information about the service said, "The people here are very well cared for, they have care staff and qualified nurses on duty. I visit every one to two weeks and I find the staff to be very good at asking for advice and also listening to the advice I give. They take appropriate action and I have no concerns that my advice is not followed correctly. The staff can tell me about the people who live here and they only call me out when appropriate."

We looked at induction and training records for three members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the service. The registered manager showed us the induction paperwork completed for staff in their first three months of employment.

Staff confirmed they completed an initial day's induction which orientated them to the service and covered corporate information such as employment issues, policies and procedures and layout of the building. Each new member of staff then went on to complete a Skills for Care induction and they were allocated a member of staff to mentor them. Skills for Care is a nationally recognised training resource. We saw documentation that indicated new staff shadowed more senior staff for the first few weeks of employment. As they gained new skills or were deemed competent in certain aspects of care, these were signed off on their induction paperwork.

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity. The registered manager told us "Some courses are computerised, some distance learning and some face to face."

The staff told us they had supervision meetings with their line manager. The registered manager showed us their supervision plan that indicated sessions took place regularly through the year. This was confirmed by the records we looked at. Staff told us that they found the supervision sessions beneficial as they could talk about their concerns and got feedback on their working practice. The staff also said, "Sometimes we feel less supported than others. We are often very busy with a lot to do and there is not enough time to do everything."

The registered manager told us that at present annual appraisals had not been completed but this was something they were planning to carry out in 2016.

Staff within the service were monitoring and reviewing risks relating to people's mental and physical wellbeing. This meant people were kept safe and they received appropriate interventions as needed from health and social care professionals. For example, one care file had a behaviour care plan within it, which documented how staff could recognise when the person was agitated or upset through their tone of voice and body language. Staff were asked to work in pairs when supporting this person and document any episodes of aggitation. However there was no written information in the care plan about the triggers for this person's disruptive behaviour. This individual had been attending appointments with a psychologist but had been recently discharged from their care. Discussion with the staff showed that they knew the factors that might

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trigger an episode of anxiety for this person, but they had not recorded this information. This was discussed with the registered manager who said they would review the care plans as soon as possible.

The staff told us that restraint was not used in the service. The staff were able to describe what they would do if an individual demonstrated distressed or anxious behaviours. Staff said "You have to know how to approach people. We would talk to them, give them a cup of tea and distract them from whatever was upsetting them. On occasions it is best to walk away and come back a little later and try again."

We identified some concerns about the way the service obtained consent. It was not clear how the registered provider ensured that individuals had been consulted with about their care needs, and that people had agreed and consented to the care and support being provided for them. In three care files that we looked at people were deemed to lack capacity to make decisions about their health and well being. There was no information about their families having power of attorney (POA) but their families had signed their their consent forms. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and / or finances). Discussion with the registered manager indicated that when possible they obtained a copy of the POA but they were still following up in a number of cases.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that four people who used the service had a DoLS in place around restricting their freedom of movement. Each of the four people required an escort when leaving the service to keep them safe whilst out and about in the community. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS. Staff had completed training on Mental Capacity awareness during the last year and were aware of how the DoLS and MCA legislation applied to people who used the service and how they were used to keep people safe.

We asked the registered manager about best practice within the service looking at external awards, dementia work and research. The registered manager confirmed there were none in place, the only best practice input came from the dementia care training given to staff.

We asked staff about how they used the training they received around dementia care in their everyday working practices, and received some good feedback. The staff talked about speaking to people clearly and giving them chance to respond to the conversations. One member of staff said "We make sure that people wear their spectacles or hearing aids so they can see and hear clearly, which helps them orientate themselves and reduces their confusion". Other staff told us, "We ask people if they need anything; they each have their own way of communicating and we treat people as we would expect to be treated – with respect and dignity" and "We show them options such as clothing or meals and we give them time to respond."

One member of staff explained that they used a picture board to communicate with one person with dementia. They said, "The signs help them let us know what they want. We also look for non verbal clues such as signs of pain, body language and facial expressions" and "The registered manager will introduce us to new people and show us the risk assessments and explain how they move, how they communicate and they remind us to ask people how they are and talk about their family."

We saw people were supported to eat and drink sufficient amounts to meet their needs. We saw that cold drinks were provided in a number of people's bedrooms and people received snacks and drinks mid morning and afternoon.

Requires improvement

Is the service effective?

Care plans documented what people's preferences were and their food likes and dislikes. For example, one person's care plan said, "I have breakfast in my bedroom" and "I enjoy going for meals out."

We received a mixed response from people when we asked them about the quality of their meals. The majority of people said they were very happy with the food given to them. One person told us, "The food is mainly very good. I am diabetic and they are very accommodating. They know what I can have." Another person told us, "The food is okay although not a lot of choice. I get what's put in front of me. I get a glass of sherry every day." No one was able to tell us what was on the menu for the day or that there was any choice, although people did say "If you really didn't want the meal that day you can have a sandwich." One person said "The food is good, it tends to repeat itself each week. I'm not sure what it is today. The staff know my preferences so will substitute food for the things I like."

Another person commented "The food's not the best. It's too regimentated for me, I like spicy and different flavours. They will do the odd curry occasionally for me. There isn't much choice though and you can work out what the dish of the day is for example its Thursday so it will be chicken. Sunday lunch alternates between beef and turkey". This person went on to say "If I didn't want chicken today I could ask for a sandwich. Teatime there is a bit more variation, things like eggs on toast, omelettes, quiche and jacket potatoes."

From our observations of the dining room experience we saw that people lacked interaction with staff and that some staff practices could be improved. For example, we saw two care staff helping two people with their meal. Both people required a soft diet. We saw that their meals were left on the side (with no cover) whilst they were given their soup from a plastic beaker using a spoon. The care staff were in good position to help each person. However, we noted there was not a lot of interaction with the person they were assisting, although staff did converse with each other. The plated meal which had been sat on the table for at least 10 minutes was given to the person using a spoon. We noted that the member of staff did not check the temperature of the meal to ensure it had not gone cold, and they didn't check the person's mouth was empty before offering another spoonful, as at one point one person spat out their food.

The rest of the dining room was very quiet as other staff came in and out serving meals. Everyone had been offered a sherry between the soup and main course. We observed that people were not very engaged with eating. However, once two further members of staff came in to prompt them most plates were cleared. There was a choice of dessert and each person was asked their preference.

We discussed people's care with different members of staff. Staff demonstrated to us that they were aware of what care each person required to meet their needs. Staff were able to say which people had input from the district nurse or dietician; they also knew what health problems each person had and what action was needed from them to support the person. Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. However, the way this information was recorded in the care plans could be improved. For example, the nutritional care plan for one person said staff were to give the person 'texture C type diet' and 'stage one' thickened fluids but gave no details of what a texture C diet was. Another care file documented that the person was concerned by their weight and a dietician had visited and advised them on the foods they should or should not eat. However, there was no written evidence of the visit.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Good

Is the service caring?

Our findings

Every person that spoke with us was happy with the care they received at the service. People commented that, "The staff are brilliant, " "They are lovely staff - they are all very kind" and "The staff always treat me well. They don't rush or push me". One person said "I have been here a long time. The staff are really good, they work very hard. We have a good rapport and a laugh sometimes."

We observed that there were good interactions between the staff and people, with friendly and supportive care practices being used to assist people in their daily lives. We did not see any care staff sitting and chatting with people, but when they were carrying out a task such as giving someone a drink the staff member would have a few words. Clear explanations were given to people as to what staff were doing. For example, a member of staff said to one person, "Hello. I will take you to the conservatory, is that okay?" We saw they made eye contact with the person and were very attentive and chatted all the way to the conservatory.

People told us that staff respected their privacy and dignity and we observed staff knocking on people's doors and asking them if it was alright to continue with what they needed to do. We noted staff spoke appropriately with people. One person told us, "The staff help with my personal care. They are very discreet and there are always two of them. On the whole I am very happy. The girls work very hard - I have a good rapport with them."

We saw that staff spoke in thoughtful, caring ways to individuals and it was obvious that they knew each person's likes and dislikes. One member of staff told us, "You get to know people using the service. I just talk to them and get to know their likes and dislikes." There is enough time in our working day to spend talking with people. We look through the care plans everyday – we need to know what care a person requires and what their needs are. Care files are okay, you can easily find what you need in them. I have no concerns about them and they are easy to access."

We found that people who used the service were dressed in clean, smart, co-ordinating clothes. Their hair was brushed and many had been to the hairdressers, including the males. Finger nails and hands were clean and well cared for and gentlemen were clean shaven (if that was their choice). We were told by people that they could have a bath whenever they wished and one person said "The carers are particularly good, caring and willing." Another person described how they had come into the home for a couple of weeks to see if they liked it. This person said "I am very impressed with the place and am perfectly content to be here."

We saw that visitors came to the home throughout the day and that they were made welcome by staff. They chatted to other people who lived at the home as well as their relative or friend. Family members told us that they are made to feel welcome at all times and that they were well looked after. Relatives told us, "Everyone is treated as an individual - the staff treat people as they need to be treated. They are calm and reassuring with people" and "The actual care has been really good. The interactions I have noted with staff to people who use the service have been really nice and it has been genuine." Staff told us they enjoyed working in the home. They said they had a good range of equipment to help them meet people's needs including hoists and slings, safe bed rails and that the environment was safe and secure. One member of staff told us, "I like it here, it is nice and the people living in the service are lovely."

Requires improvement

Is the service responsive?

Our findings

The service was not responsive around some aspects of care. We found that people who used the service had little or no input to the development of their care plans and we found that people's care plans did not always clearly describe their needs. We saw no evidence to suggest that people were not receiving the care they required, but noted this information was not well recorded. Discussion with the registered manager indicated that this had been recognised through their care plan audits and was the reason for the introduction of a new care plan format. We were not given a date for when all the care files would be transferred to the new format.

The care files we looked at included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. All the relatives we spoke with were able to tell us they were involved in developing their relative's care file. One relative told us, "We were involved in the care plan at the start. It seems to be a flexible plan which is updated regularly to capture [Name's] condition. I have signed it."

However, not everyone who spoke with us was aware they had a care file, although some people said there was a folder containing their information. No one could remember the last time they were involved in discussion about their recent care and support. One person said "There is a big yellow folder which I know tells them all about me. I haven't seen it or signed it but they are fully supporting my needs."

We looked at a selection of care files and found that the care plans lacked detail. For example one person was assessed as being at high risk of pressure sores, but their care plan lacked clarity of what action staff were to take. The care plan documented that "[Name] needs staff to assist fully to ensure regular pressure relief is maintained." It did not say how often the person required pressure relief, what areas were at risk or if the person already had any skin integrity issues. We saw that this person did have a chart in their room for staff to record when they had given the person pressure relief, but this was not always completed appropriately. On the day of our inspection it showed the person was given pressure relief in bed at 03:00 and 07:00 but did not document how often this should have taken place.

One care plan documented that "[Name] needs assistance to cut up food as necessary into manageable pieces and to assist with feeding as needed." This information was vague and not clear about the type of support this person required and when. We saw another file had a nutrional risk assessment that instructed staff to "Watch out for obesity" but there was no written evidence that staff had taken any action with regard to this. We looked at one care file that contained a care plan for wound care being carried out by the nurses employed at the service. The information about the actual wounds was detailed and descriptive and staff had recorded each time the wound was redressed. However, we did not find any description of the dressing plan showing what was being used to clean and redress the wound areas. This meant any new nurse on duty or agency staff would find it difficult to know what the correct procedure to follow was.

We also found examples of cather care plans that did not list what size catheter was being used or who was responsible for changing the catheter such as the nurses employed in the home or District Nurses. We saw a care plan for aspiration (inhalation of fluid or food into the lungs) which stated "Staff to be aware of correct procedure should [Name] choke" but this had no further details about the support needed.

We recommend that the service considers advice and guidance from a reputable source, on record keeping, in relation to care plans.

People who used the service said they didn't think there was that much to do in the service with regard to social activities, although people did describe quizzes, chair exercises, flower arranging and craft work. We saw there were some posters on display advertising visiting entertainment, but did not see a weekly calendar of activity events to help people plan what they wanted to do. We met one person who was making a cross stitch purse but we were not sure if this activity had been introduced by the service or by their relatives.

A few people said they liked to read and we noted that there were plenty of quiet areas around the service to facilitate this. People had televisions in their rooms so they could watch their favourite programmes as needed. One person had a computer to keep in touch with their family and up to date with national news; they also enjoyed knitting and the staff encouraged them to do this.

Requires improvement

Is the service responsive?

One person said "I can go out when I want really and often go to the pub. We don't have any outings as such though. Although I could book a taxi and pay a member of staff to come shopping with me; they are pretty flexible as long as you give them a bit of notice." When we asked what the home could do better four people said they would like to be able to get out more. Discussion with the registered manager indicated that three people often left the home to go into the community independently as they were fit and able to do this.

Discussion with the registered manager indicated that one person came into the home three times a week to do quizzes with people and there was a singer who entertained every month. There was also a sweet shop run by the staff. We saw that there were three different entertainers and a Christmas craftwork afternoon booked for November 2015 and in December 2015 a music session had been arranged. The activity sheets we looked at indicated that people did one to two activities per week. The registered provider employed two activity coordinators who worked four hours and six hours respectively in the service. A newsletter was also produced to keep people informed about events in the home.

We spoke with staff about how they supported people's religious and cultural needs. They told us that there were church services held 'in-house' every month that were essentially Church of England faith, the Catholic church sent in representatives on request from people using the service and a local Rabbi visited one individual. Another person went out to their local church each week to attend the Sunday service.

We found that a copy of the registered provider's complaints policy and procedure was on display near to the registered manager's office. Most people who spoke with us knew how to raise a concern although we did not see any leaflets anywhere else. One person said, "If I have any problems I would speak to the owner, it's good to have them on site" and a relative said, "(The owner) is very personable - we have an easy relationship. Also if there was an issue we would be able to bring things up."

Only one person we spoke with told us they had needed to raise any concerns. This person told us, "There have been issues in the past but they are sorted now. The management listened and sorted out the problem." Another relative said "We are very happy - it's very straightforward - if there have been issues they have been resolved quickly." This showed that the service listened to people's opinions and viewpoints and provided them with information and explanations about care and care practices.

We found that there was no formal complaints log or audit of complaints carried out by the registered manager. We were told that any complaints were dealt with then filed in people's care files. Staff told us "We go to the manager or deputy manager if someone complains. Afterwards they will tell us in handover if there is anything to do from the complaint such as a change in practice or if something needs to be happening that is not."

Requires improvement

Is the service well-led?

Our findings

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and health/social care professionals who spoke with us or gave us written feedback. Everyone said the culture of the service was open, transparent and sought ideas and suggestions on how care and practice could be improved.

There was a registered manager in post who was supported by a deputy manager and an office administrator. Everyone who spoke with us was able to tell us the name of the owner and the registered manager and were confident about raising any issues with either one of them. People told us they felt the home was well run and they were happy there. The home had a calm atmosphere about it on the day of the inspection and the owner told us they aimed to give people a 'peaceful' experience.

Staff told us the service was well led. One member of staff said, "I am trying to get someone I know to come into the home. For me to recommend it then it has to be good." Another member of staff said "The registered manager understands what our needs are and they are sensitive to these and supports us."

Although people and staff had commented to us about the values and culture of the service, the registered manager told us that there was no written information about the vision, values or culture of the service. This meant that there was a lack of evidence that all staff were clear about the aims of the service and what was expected of them.

We found that there was a quality assurance system in place but it could be developed further. We found during our inspection that care files and medicines were being audited but we had concerns about both of these areas of practice, which made us question how effective the audits were. We saw that audits of accidents and incidents, complaints and infection control practices were not carried out. We also noted that some record keeping was not effective; regular audits may have identified the improvements that needed to be made. Without this information the registered provider may find it difficult to evidence how they are effectively monitoring the quality of the service and staff practices.

Two of the people we spoke with mentioned the residents' meeting that according to the notice on the dining room door was held every last Friday of the month. Only one these people told us they attended sometimes. This person said "I am not sure if they are useful, it depends on what the issues are. At the last meeting there was an issue around the vegetables at meal time and the fact that there isn't much variation. People asked for different vegetables and presentation; for example roasted vegetables instead of always boiled. Nothing has changed as yet."

We saw that three 'resident' meetings had been held in the last six months. We looked at the minutes of the last meeting held on 2 October 2015. People had made lots of different suggestions about activities and some had asked for a less bland diet. However, from what we saw and heard from people using the service there did not appear to have been many changes made from the feedback given to the management team. We saw that the minutes from the meeting held in March 2015 had not been typed up and that the folder containing the minutes was not in an area where people could easily access it. We asked the registered manager how feedback was given to relatives and residents if the meeting minutes were not available. We were told that feedback was given verbally to individuals who asked.

When we asked the registered manager about meetings for the care staff we were told these had not taken place. Discussion with the registered manager indicated that face to face supervision meetings took place and sometimes they rang the night staff to discuss any issues that may have arisen. Staff received a handover sheet at the start of every shift that kept them up to date with any changes in people's conditions and health. Staff told us they found these very helpful.

We recommend that the service considers current best practice on quality assurance systems and takes action to update their practice accordingly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.** **The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity.** **Regulation 12 (1) (2) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Meeting nutritional and hydration needs.** **The registered provider failed to meet people's nutritional and hydration needs through a lack of quality, choice, menus, the dining experience and how people were supported. Information about nutritional and hydration needs was poorly recorded.** **Regulation 14 (4) a - d**